

## § 442.110

### § 442.110 Certification period for ICFs/MR with standard-level deficiencies.

(a) Facilities with deficiencies may be certified under § 442.105 for the period specified in either paragraph (b) or (c) of this section.

(b) The survey agency may certify a facility for a period that ends no later than 60 days after the last day specified in the plan for correcting deficiencies. The certification period must not exceed 12 months, including the period allowed for corrections.

(c) The survey agency may certify a facility for up to 12 months with a condition that the certification will be automatically canceled on a specified date within the certification period unless—

(1) The survey agency finds that all deficiencies have been satisfactorily corrected; or

(2) The survey agency finds and notifies the Medicaid agency that the facility has made substantial progress in correcting the deficiencies and has a new plan for correction that is acceptable.

The automatic cancellation date must be no later than 60 days after the last day specified in the plan for correction of deficiencies under § 442.105.

[43 FR 45233, Sept. 29, 1978. Redesignated and amended at 53 FR 1993, Jan. 25, 1988; 59 FR 56236, Nov. 10, 1994]

### § 442.117 Termination of certification for ICFs/MR whose deficiencies pose immediate jeopardy.

(a) A survey agency must terminate a facility's certification if it determines that—

(1) The facility no longer meets conditions of participation for ICFs/MR as specified in subpart I of part 483 of this chapter.

(2) The facility's deficiencies pose immediate jeopardy to residents' health and safety.

(b) Subsequent to a certification of a facility's noncompliance, the Medicaid agency must, in terminating the provider agreement, follow the appeals process specified in part 431, subpart D of this chapter.

[51 FR 24491, July 3, 1986, as amended at 59 FR 56236, Nov. 10, 1994]

## 42 CFR Ch. IV (10–1–99 Edition)

### § 442.118 Denial of payments for new admissions to an ICF/MR.

(a) *Basis for denial of payments.* The Medicaid agency may deny payment for new admissions to an ICF/MR that no longer meets the applicable conditions of participation specified under subpart I of part 483 of this chapter.

(b) *Agency procedures.* Before denying payments for new admissions, the Medicaid agency must comply with the following requirements:

(1) Provide the facility up to 60 days to correct the cited deficiencies and comply with conditions of participation for ICFs/MR.

(2) If at the end of the specified period the facility has not achieved compliance, give the facility notice of intent to deny payment for new admissions, and opportunity for an informal hearing.

(3) If the facility requests a hearing, provide an informal hearing that includes—

(i) The opportunity for the facility to present, before a State Medicaid official who was not involved in making the initial determination, evidence or documentation, in writing or in person, to refute the decision that the facility is out of compliance with the conditions of participation for ICFs/MR.

(ii) A written decision setting forth the factual and legal bases pertinent to a resolution of the dispute.

(4) If the decision of the informal hearing is to deny payments for new admissions, provide the facility and the public, at least 15 days before the effective date of the sanction, with a notice that includes the effective date and the reasons for the denial of payments.

[51 FR 24491, July 3, 1986, as amended at 59 FR 56236, Nov. 10, 1994]

### § 442.119 Duration of denial of payments and subsequent termination of an ICF/MR.

(a) *Period of denial.* The denial of payments for new admissions will continue for 11 months after the month it was imposed unless, before the end of that period, the Medicaid agency finds that—

(1) The facility has corrected the deficiencies or is making a good faith effort to achieve compliance with the

conditions of participation for ICFs/MR; or

(2) The deficiencies are such that it is necessary to terminate the facility's provider agreement.

(b) *Subsequent termination.* The Medicaid agency must terminate a facility's provider agreement—

(1) Upon the agency's finding that the facility has been unable to achieve compliance with the conditions of participation for ICFs/MR during the period that payments for new admissions have been denied;

(2) Effective the day following the last day of the denial of payments period; and

(3) In accordance with the procedures for appeal of terminations set forth in subpart D of part 431 of this chapter.

[51 FR 24491, July 3, 1986, as amended at 59 FR 56236, Nov. 10, 1994]

### Subparts D–F [Reserved]

## PART 447—PAYMENTS FOR SERVICES

### Subpart A—Payments: General Provisions

Sec.

447.1 Purpose.

447.10 Prohibition against reassignment of provider claims.

447.15 Acceptance of State payment as payment in full.

447.20 Provider restrictions: State plan requirements.

447.21 Reduction of payments to providers.

447.25 Direct payments to certain recipients for physicians' or dentists' services.

447.30 Withholding the Federal share of payments to Medicaid providers to recover Medicare overpayments.

447.31 Withholding Medicare payments to recover Medicaid overpayments.

447.40 Payments for reserving beds in institutions.

447.45 Timely claims payment.

#### COST SHARING

447.50 Cost sharing: Basis and purpose.

#### ENROLLMENT FEE, PREMIUM OR SIMILAR COST SHARING CHARGE

447.51 Requirements and options.

447.52 Minimum and maximum income-related charges.

#### DEDUCTIBLE, COINSURANCE, CO-PAYMENT OR SIMILAR COST-SHARING CHARGE

447.53 Applicability; specification; multiple charges.

447.54 Maximum allowable charges.

447.55 Standard co-payment.

447.56 Income-related charges.

447.57 Restrictions on payments to providers.

447.58 Payments to prepaid capitation organizations.

#### FEDERAL FINANCIAL PARTICIPATION

447.59 FFP: Conditions relating to cost-sharing.

### Subpart B—Payment Methods: General Provisions

447.200 Basis and purpose.

447.201 State plan requirements.

447.202 Audits.

447.203 Documentation of payment rates.

447.204 Encouragement of provider participation.

447.205 Public notice of changes in State-wide methods and standards for setting payment rates.

### Subpart C—Payment For Inpatient Hospital and Long-Term Care Facility Services

447.250 Basis and purpose.

#### PAYMENT RATES

447.251 Definitions.

447.252 State plan requirements.

447.253 Other requirements.

447.255 Related information.

447.256 Procedures for HCFA action on assurances and State plan amendments.

#### FEDERAL FINANCIAL PARTICIPATION

447.257 FFP: Conditions relating to institutional reimbursement.

#### UPPER LIMITS

447.271 Upper limits based on customary charges.

447.272 Application of upper payment limits.

#### SWING-BED HOSPITALS

447.280 Hospital providers of NF services (swing-bed hospitals).

### Subpart D [Reserved]

### Subpart E—Payment Adjustments for Hospitals That Serve a Disproportionate Number of Low-Income Patients

447.296 Limitations on aggregate payments for disproportionate share hospitals for the period January 1, 1992 through September 30, 1992.